AESTHETIC DENTAL DESIGNS

NEW PATIENT FORM

Welcome to the premiere family and cosmetic dentistry destination, where our goal is to provide our patients with a lifetime of healthy smiles by offering the same care and concern we would desire for our family and friends. You deserve the best and we offer the best.

PATIENT INFORMATION

To assist us in serving you, please complete the following confidential form.The information provided is important to your dental health.

Patient's Name: _____ Date of Birth: _____

Patient's Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell: _____

Email Address: _____ D L: _____

Sex: ☐ Male ☐ Female ☐ Single ☐ Married ☐ Divorced ☐ Child

Relationship to Responsible Party: ☐ Self ☐ Spouse ☐ Dependant SSN: _____

Reason for Appointment: _____

Referred by: _____ Employer: _____ Occupation: _____

Employer's Address: _____ City: _____ State: _____ Zip: _____

FINANCIALLY RESPONSIBLE PARTY

Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ SSN: _____

Employer: _____ Occupation: _____ D L: _____

Employer's Address: _____ City: _____ State: _____ Zip: _____

DENTAL INSURANCE

We will bill your insurance company for you, however, it is extremely important that we have all of your insurance information.

Primary Carrier

Insurance Co. Name: _____ Insured's Name: _____

Insured's Employer: _____ Insured's SSN: _____

Patient's Relation to Insured: _____ Insured's DOB: _____

Group I.D: _____ Do you have any other Dental Insurance? ☐ Yes ☐ No

Secondary Carrier

Insurance Co. Name: _____ Insured's Name: _____

Insured's Employer: _____ Insured's SSN: _____

Patient's Relation to Insured: _____ Insured's DOB: _____

Group I.D: _____ Do you have any other Dental Insurance? ☐ Yes ☐ No

MEDICAL HISTORY

Physician: _____ Date of Last Physical Exam: _____

Have you been a patient in the hospital during the past two years? ☐ Yes ☐ No
If so, for what? _____

Have you been under the care of a medical doctor during the past two years ☐ Yes ☐ No
If so, for what? _____

Have you taken any medicine or drugs durning the past two years? ☐ Yes ☐ No
If so, for what? _____

Are you allergic to (i.e., itching, rash, swelling of hands, feet or eyes) or made sick by penicillin, aspirin, codeine, or any drugs or medications? ☐ Yes ☐ No
If so, for what? _____

Have you ever had any excessive bleeding requiring special treatment? ☐ Yes ☐ No

Are you on a special diet? ☐ Yes ☐ No

Has your medical doctor ever said you have cancer or a tumor? ☐ Yes ☐ No

Do you have any type of non-dental implant (i.e., breast, chin, cheek, etc)? ☐ Yes ☐ No

Do you require pre-medication? ☐ Yes ☐ No Are you pregnant now? ☐ Yes ☐ No

Taking birth control pills? ☐ Yes ☐ No Do you anticipate becoming pregnant? ☐ Yes ☐ No

Have you ever had any of the following medical problems? Check appropriate box for all conditions:

Yes	No		Yes	No		Yes	No	
☐	☐	High blood pressure	☐	☐	High cholesterol	☐	☐	Emphysema
☐	☐	Heart disease or attack	☐	☐	Blood transfusion	☐	☐	Asthma
☐	☐	Heart murmur	☐	☐	Thyroid disease	☐	☐	Cough
☐	☐	Rheumatic fever	☐	☐	Fainting or dizzy spells	☐	☐	Sinus trouble
☐	☐	Artificial heart valve	☐	☐	Allergic to latex	☐	☐	Stroke
☐	☐	Heart pacemaker	☐	☐	Allergic to tape	☐	☐	Diabetes
☐	☐	Hepatitis	☐	☐	Allergic to golds or metals	☐	☐	Hay fever
☐	☐	Cancer treatment	☐	☐	Artifical joint	☐	☐	Hemophilia
☐	☐	Psychiatric treatment	☐	☐	Rheumatism	☐	☐	Sickle cell
☐	☐	Pain in jaw joints	☐	☐	Arthritis	☐	☐	Epilepsy or
☐	☐	Tuberculosis	☐	☐	Nervousness			seizures
☐	☐	Yellow jaundice	☐	☐	AIDS/HIV	☐	☐	Glaucoma
☐	☐	Kidney trouble	☐	☐	Bruise easily	☐	☐	Anemia

Are there any other conditions not listed above? If so what are they? _____

I hereby authorize and request my insurance company to pay directly to the doctor the amount due on my claim for services rendered to me or my dependent. I further agree that I am responsible for the entire amount of dental and surgical expense, should the nature of the treatment be such that it is not entirely covered by my policy. A photostat of this authorization shall be valid as original. I understand an appointment is a confirmation. There will be no charge to reschedule appointments providing I give a 24-hour advance notice (calls must be received 8-5:00, Mon-Thurs). Otherwise I will be subject to a $25 per 1/2-hour fee for not showing or canceling the day of my appointment. To the best of my knowledge, all of the preceding answers are true and correct. I understand that providing incorrect information can be dangerous to my health or if my medicines change, I will inform the Doctor of Dentistry at the next appointment without fail. I hereby consent to the treatment indicated on my examination form, including the use of any anesthetics, sedatives, or X-rays, as may be deemed necessary by the Doctor of Dentistry in attendance. I authorize the Doctor of Dentistry to release any information including diagnosis and the records of any treatment or examination to me or my child during the period of such Dental Care to the third party payer's and/or health practioner's.

Signature of Patient or Guardian and date: _____

Signature of Doctor and date: _____